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M e m o r a n d u m

To: Lusine Khachoyan Janoyan, Administrator
Tarzana Health and Rehabilitation Center

Date: April 27, 2012

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From: Operation Guardians
Bureau of Medi-Cal Fraud and Elder Abuse - Sacramento
Office of the Attorney General

Subject: Operation Guardians Inspection

On March 6, 2012, the Operation Guardians team conducted a surprise inspection of Tarzana Health and Rehabilitation Center. The following summary is based upon the team's observations, plus documents and information provided by the facility.

SUMMARY OF RESIDENT CARE FINDINGS:

1. The team nurse observed the Resident in Room 63A receiving oxygen via nasal cannula at 4 L/minute without a humidifier. Dry oxygen delivered through the nose or mouth tends to cause dry, sore throats and oral tissues. The humidifier should have been in place to provide moisture and comfort for the resident

2. Room 70 was observed as being in isolation as a sign was posted "Do Not Enter, See Nurse Before Entering" and a cart containing isolation supplies was at the resident's door. The door of the room was open and the team observed two staff members in the room donned in gowns, gloves and masks. It was unclear to the team nurse why the staff was wearing masks (usually utilized for airborn infections) when the door to the resident's room was open. This was brought to the attention of the facility's Director of Nurses (DON) who reported the resident was in contact isolation only. She was not aware the staff was wearing the masks and reported the process was not necessary.

3. The medical record review of Resident 11-09-01 indicated he was receiving a large amount of antipsychotic medications, including Remerol for "poor oral intake and depression," Ativan for "resistive to care," Effexor- for "verbalization of sadness," and Seraquel. There was no diagnosis of Dementia or behaviors in the physician's history and physical. The FACE SHEET updated by the facility 2/28/11 for his most recent admission date to the facility, did not include a diagnosis of depression, dementia or behaviors. Review of the Medication Administration Record did ot indicate the nurses were observing ANY behaviors that would warrant administration of anti-psychotropic medications. There was nothing seen in the chart that indicated why this resident was being medicated with antipsychotic medications without a documented diagnosis and significant behaviors.

4. While the team was performing the walk-through of the facility, the team observed orange straps lying on the floor under the foot of Resident 11-09-02's bed. The team nurse determined the straps were elastic exercise bands. The resident reported he was not sure why they were lying on the floor as they should have been in his bed where he could reach them for his exercises.

The resident reported to the team he was missing an electric wheelchair that was fitted for him when he resided at a previous Rehabilitation Center. Without the chair the resident could not get out of bed to be properly positioned following back surgery. He also reported he wanted to be transferred to another facility that could better provide for his needs, i.e. more progressive therapy. The resident expressed concern that he had been moved from facility to facility-- either by his request after hospitalizations, or for other reasons that were unclear.

Review of the resident's medical record indicated he had been admitted to the facility on 2/15/12 with Quadriplegia, Chronic Obstructive Pulmonary Disease, History of Myocardial Infarction, Epilepsy, Acute Bronchitis, Backache, and Malnutrition. According to the progress notes, a physician had not examined or evaluated the resident since admission. The resident was receiving a Fentanyl patch "for pain" but there was no indication from the nursing documentation the location of the pain or whether the patch was providing relief from pain. The medical chart also indicated the resident was receiving Depakote for depression. However, there was no diagnosis of depression in the resident's medical documents.

The team nurse discussed the care plan with the resident's Physical Therapist and the fact that exercise bands were found under the resident's bed. There was concern that the resident was not being provided with active therapy to prevent further decline. The therapist reported he was having in-depth conversations with the resident and had obtained pertinent health care findings as well as a significant medical history from the resident. The team nurse discussed with the therapist that "his significant and valuable medical information" was not documented in the chart and the nursing staff and social worker could greatly benefit from the information. It was evident to the team nurse there was no interdisciplinary communication between the physical therapists and nursing staff.

It was also noted that the resident's medical chart stated the resident had previously resided at Colonial Care Facility, but the address on the resident's FACE SHEET was 2635 Honolulu Avenue, Montrose, 91020 which is the address for Verdugo Valley Skilled Nursing and Rehabilitation. This address was also listed for the resident's son, the designated emergency contact. It appeared from reviewing the medical records the facility did not have the correct emergency contact information or pertinent medical information to establish the required care for the continuity of the resident's health care needs.

5. Resident 11-09-03 was observed in bed with the head of her bed elevated approximately 40 degrees. She was coughing and appeared to need to expectorate her secretions as her lungs sounded "moist." The team nurse asked the licensed nurse passing the resident's medications about the condition of Resident 11-09-03. She reported the resident had Robitussin for her cough and when asked if the resident typically had a moist cough and this was normal for her lung statuss, the licensed nurse was unable to answer the question. Review of the Medication Administration Record (MAR) indicated the resident had Robitussin ordered for a cough, but had not been receiving the medication. The team nurse requested the licensed nurse notify the Registered Nurse to assess the resident, or to notify the resident's doctor if the moist cough was a change in the resident's condition.

   The review of the nurses' notes showed there were no notes documented on the resident after

2/21/12. The most current Weekly Nursing Summary Note was dated 2/24/12 and was not signed by a licensed nurse. The Summary did not indicate the resident was having any pulmonary problems. However, it should be noted the Facility Form did not have a documentation section for the nurses to assess and document the resident's Respiratory status.

6. The medical review of Resident 11-09-04 showed she was to receive physical therapy services six (6) times a week from 2/18/12 through 3/16/12. On 2/20/12, according to the Rehab Notes, the resident refused exercises. On 2/21/12, the resident refused to participate in out-of- bed (OOB) activities and "said she did not want anybody touching her." On 2/24/12, the Rehab Note again states the resident "still refused to participate with OOB activities/exercises." According to the Physical Therapy Service Log Matrix, the resident refused the service on 2/20/12. On 2/21 & 2/24 the form shows minutes documented for *therapeutic exercises*, *therapeutic activities* as well as *neuromuscular re-education*. It appears the total amount of time charged for the services was 60 minutes on each date. It is unclear how the facility was able to charge for physical therapy minutes when the Rehab documentation indicated the resident refused the services.

FACILITY ENVIRONMENTAL OBSERVATIONS:

1. An extension cord in Room 40 appeared to be in constant use as the team observed the resident's oxygen concentrator plugged into the cord. This violates the state fire code.

2. The linen closet located by Room 34 was observed with clean linen and plastic debris on the floor. This is an infection control issue.

3. The shower room, located across from Room 64, was observed with an exposed three inch drain hole in the middle of the floor. For the safety of the residents, the exposed hole required immediate attention and the placement of a drain cover.

ADMINISTRATIVE OBSERVATIONS:

1. The facility indicated there were twelve residents on bedfast. The OG team observed numerous other residents including rooms, 3B, 12 B, 12C, 18B, 20B, 22A, 22B, 64A, 64B, 83A, 83B, 85A, and 86C that were not out of bed during the inspection time.

2. A majority of the facility residents were observed eating meals in bed, particularly the breakfast meal. The facility had a high number of residents requiring assistance with their meals and it did not appear there was sufficient staff to feed the residents. The team was uncertain if residents were eating in their beds by choice, or they were not given the opportunity to be taken to the dining room. This is a residents' rights issue.

3. Many of the facility staff were not wearing name tags. Some were observed with their name written on a piece of tape applied to their uniforms. This is a resident safety issue.

4. The facility's "Resident Abuse Investigation Policy and Procedures" was not in compliance with California state law. California law requires that the individual that witnesses or suspects abuse

or neglect is required to fill out an SOC 341 form, not the Administrator. An individual facility's investigation into suspected neglect or abuse is completely separate from what is required under California law. Any employee of a facility can be charged with a "failure to report" for failing to follow this law. We would suggest that the Administrator and staff review the Department of Justice mandated training materials and video entitled "Your Legal Duty: Reporting Elder and Dependent Adult Abuse."

STAFFING:

Based on the January and February 2012 records provided by the facility, staffing levels were within the minimum required 3.2 hours per resident day (hprd) on all six days randomly reviewed. The average hprd was 3.6 hours. It should be noted that providing the minimum number of nursing hours does not always indicate nursing care is sufficient to meet the needs of the residents.

CONCLUSION:

Please be advised that this is a summary of information available to us at this time. Should further information develop from the efforts of Operation Guardians, we will notify you at the appropriate time.

The Operation Guardians inspection does not preclude any Department of Health Services complaint or annual visits, any law enforcement investigation or other licensing agency investigation or inspections, which may occur in the future. A copy of this report is being forwarded as a complaint to the Department of Health Services. This inspection does not preclude any further Operation Guardians unannounced inspection.

We do not require that you submit a plan of correction regarding the findings of the Operation Guardians inspection. However, at some future time, the contents of this letter may be released to the public.

We encourage your comments so they can be part of the public record as well. Please send any comments to, Cathy Long NEII, at 1425 River Park Drive, Sacramento, California 95815, phone: (916) 274-2913 or Peggy Osborn at (916) 263-2505.

Operation Guardians
Physician's Report
Kathryn Locatell, MD
April 27, 2012

Tarzana Health and Rehabilitation Center
March 6, 2012

The care of 15 residents was reviewed. Current problems with psychotropic medication practices and end of life care are attributable in part to substandard physician services. Deficient nursing care and monitoring contributes to these problems, and to the development of avoidable pressure ulcers.

I. Physician services.

While the timeliness and frequency of visits by medical providers conform, for the most part, with current standards, the care being provided does not. These providers are using excessive numbers of medications and invasive therapies, without appropriate indications and without adequate monitoring, by either the provider or the facility's nursing staff. They are also not providing palliative and end of life care in conformance with residents' stated directives or current standards.

Resident 4 is a diabetic and is 90 years old. Her medication regimen includes twice-daily injections of long-acting insulin. This medication is considered high-risk in older persons, who may not sense that their blood sugar is low; if they miss eating a meal, both circumstances can lead to a life-threatening episode of low blood sugar ("hypoglycemia"). The current standards for the management of diabetes in older persons stress the importance of avoiding such episodes, as they may irreversibly harm the person's brain and even cause death. It is recommended that the target range for blood sugar control in the old-old (greater than 85 years of age) is set much higher than for younger persons. Resident 4's average blood sugar readings, as reflected in the result of a glycated hemoglobin test ("hemoglobin A1-c"), were far below the recommended target in August of 2011, indicating that on average her blood sugar range was low and that she may have been getting too much insulin at that time. The physician, however, had increased her insulin dose in January 2012 despite that fact, and the fact that Resident 4 had a life-threateningly low blood sugar level just 6 days earlier. The physician also had not ordered any follow up glycohemoglobin testing.

On 1/12/12, a nurse found that Resident 4's blood sugar level was 20 at 2:40 am; if this level had persisted, the resident would certainly have died. Another severe low level (25; levels below 80 are considered dangerous in this population) was recorded on 1/18 at 1 am. The attending physician visited on 2/1/12 and did not document any analysis of Resident 4's dangerous hypoglycemia, and did not order repeat glycohemoglobin testing. These deficient practices exposed Resident 4 to severe harm and death.

Physicians appear to be ordering intravenous fluid therapy without adequate indications or monitoring. Resident 2's doctor ordered IV fluids after a lab test showed some degree of dehydration. The resident's advance directive did not indicate whether she wished to receive artificial hydration, and there was no analysis by the doctor as to its risks and benefits for Resident 2. Her advance directive did indicate that she was to receive comfort measures only, which usually does not include IV fluid administration or routine laboratory testing. After completion of the course of fluids, the physician wrote an order stating: "give 4 glass fluid or IV daily". At that time, the resident was receiving two different diuretic medications, which certainly can contribute to dehydration; there was no analysis of the medication regimen by the doctor; and as, written, the order was nonsensical. As a consequence of the intravenous fluids, the resident developed considerable swelling that nurses judged uncomfortable for the resident.

Resident 14 also recently received a course of intravenous fluids and developed edema (fluid accumulation in tissues) as a result. This resident's advance directives did not specify whether she should receive artificial hydration, but here son indicated to the nurse practitioner that he was "agreeable" to treating her at the facility for a urinary tract infection that was associated with a decline in her oral intake. On the day of our inspection, the resident was clearly dying. The nurse practitioner had visited the day before and documented that Resident 14's son chose to treat her for comfort. However, the NP did not discontinue the intravenous antibiotics she was receiving or the IV catheter, both of which likely did not contribute to the resident's comfort. In addition, the resident's respiratory rate, markedly elevated in the 60s, was a potential indicator that the IV fluids she had received added to her discomfort as she was dying because the fluids also accumulated in her lungs.

In general, the medical providers' practice pattern is that of polypharmacy, they order excessive laboratory tests and IV therapy, and fail to define the goals of care or consider risks and benefits to the resident. The consultant pharmacist issues numerous recommendations to taper or stop various medications, including psychotropic agents, most of which appear to have been rejected by medical providers. Per nursing staff, the providers are also resistant to requests from nursing staff to consider reducing the numbers of medications, tests and treatments; some are plainly hostile even to the requests.

I attempted to speak with a nurse practitioner about my concerns regarding Resident 6, who is a member of the health plan that employs the NP. The NP was frankly hostile to my concerns and told me, "she's not my patient, call Dr. ____." The climate within the home of medical providers not accepting the need for collaboration with nursing and other disciplines was evident within this interaction. The practice style of the providers hampers the ability of the staff to provide adequate and appropriate care and contributed to some of the adverse outcomes observed during the inspection, discussed below.

II. Psychotropic medication practices.

Physicians are not documenting the indications for the use of antipsychotic drugs. Residents admitted from acute care hospitals on antipsychotic drugs, in particular, have no medical rationale documented by providers in the nursing home. Providers are refusing requests by the facility for dose reductions with no documented rationale.

Resident 10 was admitted from an acute care hospital with diagnoses of cellulitis, Parkinson's disease, pressure ulcers and "depression with behavioral disturbance". Prior to being hospitalized, Resident 10 was living in a residential care facility where she was being treated with a nightly dose of an antipsychotic agent. Upon admission to the nursing home, there was no documented indication of the use of this drug, by either facility staff or the attending physician. This was the only instance I found where the physician did agree to change the drug to "as needed" on recommendation of the pharmacist, a month after the recommendation was made and over 2 months after the resident's admission.

Resident 14's diagnoses included history of a brain hemorrhage due to falling; she was admitted 10 months prior for rehabilitation after surgical treatment and came into the facility with orders for an antipsychotic. The drug was continued through the day of our inspection, despite little to no documentation by either the facility or the medical provider regarding its indications, effectiveness or rationale for use. There was no documentation concerning the need for a trial reduction in dose, despite the fact that the facility's behavior monitoring record showed that she had no manifestations of any psychotic condition warranting treatment with an antipsychotic. Her condition had demonstrably declined over the past two months, with weight loss, recurring infections and loss of function, all of which may have been caused or contributed to by the antipsychotic agent. Resident 14 was also being treated with a benzodiazepine tranquilizer, for which there were also no documented behaviors, diagnosis or rationale. She had experienced numerous falls over the course of her residence, and since this class of drugs is known to double the fall risk for older persons, it was incumbent on both the facility and the medical provider to at least consider reducing or eliminating its use; however, no such consideration was documented. It is likely that the unnecessary drugs, an antipsychotic and an antianxiety agent, contributed to the resident's imminent demise.

Resident 6 was also admitted to the facility, a week prior to our inspection, with orders for an antipsychotic agent, which as with Resident 10 she had been receiving prior to the hospitalization which preceded admission to the nursing home. Resident 6 was admitted for rehabilitation, with a goal of returning to her residential care facility. However, the resident has been described as having periods of lethargy and signs of delirium and has not made any progress with therapy. She cries frequently and refuses to get out of bed. The listed indication for the antipsychotic drug is "dementia with psychotic agitated features manifested by constant calling out", yet none of these diagnoses were listed in the acute-care hospital records or by her medical provider in the nursing home; there was no consideration given to the possibility that any "constant calling out" might instead be a manifestation of an unmet care need, or of delirium. This resident is at very high risk for adverse drug effects, at age 97, and there is at the present time no indication for her to

receive this drug. It was when I approached the NP with my concern about the drug for Resident 6 that she stated that it was not "her" patient and refused to discuss it with me.

When Residents 6 and 14 were reviewed with the administrator and director of nurses, the team was informed that their medical providers were the most resistant of all the providers to any suggestions that psychotropic medications be reduced or eliminated. Considering that the providers, at the same time, are not documenting any medical evaluation, diagnosis or justification for the drugs they prescribe, it is clear that their care is not meeting current standards with respect to these drugs.

III. End of life care.

Medical providers are also not meeting current standards with respect to end of life care, and this is the same group of providers who over-prescribe psychotropics. In a number of cases reviewed, the medical providers, often a nurse practitioner, are ordering needlessly invasive lab tests, IV fluids and IV antibiotics while failing to prescribe adequate measures to enhance and ensure comfort. The standard for treating persons who have chosen to limit or forego life-sustaining interventions requires that the medical provider establish the individual's goals of care with the resident and/or responsible party and to provide care that addresses and helps accomplish those goals. Neither facility staff nor the providers are meeting this standard.

The example of Resident 14 was particularly telling. She had been diagnosed with a urinary tract infection in January and again in February, amidst a general decline and loss of weight. The nurse practitioner treated her very aggressively in both instances. The treatment for the most recent illness began at the end of February, and after one week of IV fluids and antibiotics it was apparent to the NP as of the day prior to our inspection that her condition was not improving: the NP documented having a conversation with her son wherein the son requested "comfort measures only". The NP ordered around-the-clock morphine administration but did not document telling her son that Resident 14 was dying.

Upon examination of Resident 14 the next day, we found a resident who was clearly moribund. She appeared to be in pain and was unresponsive to verbal stimuli. In discussion with nursing staff, there did not appear to be a recognition on their part that the resident was near death; she also had not received her scheduled morphine dose timely. Staff notified her family that she was nearing death and at least one family member came to the facility soon thereafter. The failure of the NP and the facility to identify the change in the resident's condition to that of an "actively dying" person, and to provide care consistent with that condition, deprived the resident of a comfortable dying process and deprived the resident's family of time to spend with her.

Resident 11, age 100, died at the facility on 1/21/12. This resident had an advance directive that states he wanted to receive limited additional interventions to sustain life as of 2010; it had not been updated as of early this year when he developed an infection of his face. The nurse practitioner had treated his "left cheek cellulitis" with intravenous

fluids and intravenous antibiotics. At a follow up visit on 1/16/12, the NP documented that she spoke with the resident's son about his "deteriorating condition"; the son was "agreeable to symptom management". However, the medical providers, including on-call physicians, continued to treat Resident 11 with lab tests and an electrocardiogram; there was no formulation of any goals of care, and no plan to adjust the intensity of interventions to match the resident's preferences and decline in condition.

In Resident 12's case, facility staff failed to keep a family member informed of the resident's dying condition. The resident's granddaughter had specifically requested on 10/21/11 that staff notify her as soon as possible "if he declines", because she lived 2 hours away and wanted to be present when he died. There were no narrative nursing notes written until 4 days later, when the resident had shallow breathing and an elevated respiratory rate. His granddaughter visited that morning and left. There was a gap in charting until 2 pm the following day, and at 6 pm the resident was near death at the time the granddaughter was notified. The nurse documented calling her at 6:25 pm; he expired at 6:30 pm. Nursing staff failed to monitor his condition adequately to recognize that he was dying and inform his granddaughter.

These 3 cases illustrate a pattern of inadequate end of life care by both medical providers and facility staff. They reflect a lack of knowledge, education or training on standards for the care of dying persons. The facility had a single hospice resident at the time of our inspection and does not appear to routinely use hospice services; given the poor care described, all concerned should acquire the training and skills needed on an urgent basis.

IV. Pressure ulcer prevention and treatment.

One case of a significant, facility-acquired pressure ulcer was reviewed. In addition, I observed what I consider to be an avoidable deep tissue injury in dying Resident 14. She was supine in bed with her right heel in direct contact with the mattress; on inspection, it was deep red to purple in color, nonblanching, with a soft, boggy texture. Staff had not repositioned her over many hours, and was not "floating" her heels. After I pointed this out to a supervisory nurse, on my return the resident had pressure relieving boots on both feet; however, the feet were not floated and were still in contact with the mattress. The primary treatment of a deep tissue injury of the heel is to ensure that all pressure is relieved, though off-loading ("floating"); boots such as those applied to Resident 14 do not relieve pressure, they only reduce it, and then only if the heels are also floated.

Resident 9 acquired a full-thickness pressure sore of the heels and right buttocks while residing at the facility for rehabilitation after a total hip replacement. Although it was determined that he was at high risk, there were no regular skin inspections: the right buttocks pressure sore was advanced before any nurse noticed it. Apparently, he or his family has taken legal action against the facility; the resident's chart was in the legal department of the facility's corporate office and a copy was left in its place.

V. Nursing monitoring.

Examples of absent or deficient monitoring are described above. One of the primary failures by licensed nurses in the home is the failure to continuously monitor residents' clinical conditions. Narrative nursing notes are either absent or are totally rote in nature. Rote entries such as "all needs met" do not satisfy the requirement to document that nursing observations and nursing care were actually conducted and provided. Documentation that is devoid of meaningful, resident-specific information does not meet any standard of care.

In one glaring example, nursing staff were informed by the resident's wife that he was having difficulty swallowing and was "pocketing food for 2 days now", according to a narrative note dated 4 days before his transfer to the hospital for altered level of consciousness. Resident 13 was treated with intravenous fluids the next day, the day after that with intravenous antibiotics. Nurses charted every shift thereafter that he had "no signs of distress" and that "all needs [were] met", while his condition (obviously, based on the outcome) continued to decline. He did not return to the facility after transfer to the hospital and according to the closed chart cover died the same day. The nursing monitoring during his last 4 days in the facility did not generally accepted standards of quality.

In conclusion, some of the deficient care observed and described in this report was attributable to substandard physician services, some to deficient nursing care and monitoring. Technical advice was provided to the administrator and director of nurses during the exit conference. It was strongly recommended that they enlist the assistance of the facility's medical director in addressing the inadequate quality of care by medical providers.